STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING _____ B. WING _____	02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN46074

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/15/11 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Maple Park Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 112 and had a census of 82 at the time of this visit.	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 LSC plan of correction be considered the letter of credible allegation and request a desk review, in lieu of a Post Survey review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/18/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0027	Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors formed a smoke resistant barrier. This deficient practice could affect any resident, staff or visitors in the vicinity of the Hall 2 south smoke barrier door set if smoke was allowed to move from one smoke compartment to another. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 02/15/11, the door handle in the Hall 2 south cross corridor smoke barrier door set was loose in the door which created a one half inch opening through the door which was not resistant to the passage of smoke. Based on interview at the time of observation, the Maintenance Director acknowledged the door handle in the smoke barrier door set was loose creating an opening through the smoke barrier door set which is not resistant to the passage of smoke. 3.1-19(b)	K0027	**K027 NFPA 101 Life safety code standard** The facility does provide smoke barrier doors with 20-minute fire protection rating. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** There were no residents identified as affected. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** There were no residents affected however to residents on the 200 hall had the potential to be affected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The door handle was replaced with one that is easily tightened. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** The Maintenance Supervisor will check the handle monthly during the monthly activation of the door panel to ensure the handle remains tightened. **Compliance date: 03-08-11**	03/08/2011

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K0038	Based on observation and interview, the facility failed to ensure means of egress are free of impediments at all times in accordance with LSC Section 7.1. LSC Section 7.1.10.1 states means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect any resident, staff or visitor evacuated through the 200 Hall north exit in the event of an emergency. Findings include: Based on observation with the Maintenance Director during the tour of the facility from 11:00 a.m. to 1:00 p.m. on 02/15/11, the 200 Hall north exit discharges onto a concrete patio surrounded by a fenced area outside the 200 Hall north exit. The exit gate for the fenced area for the 200 Hall north discharge path was locked with a padlock thereby blocking access to the public way. Based on interview at the time of observation, the Maintenance Director acknowledged no key is provided for the padlock at the gate and acknowledged the 200 Hall north exit discharge path to the public way is not a provided with a continuous path free from obstruction.	K0038	**K 038 Exit Access** The facility does provide an exit access so that exits are readily accessible at all times. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** There were no residents identified **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** There are no residents identified, residents on the 200 hall have the potential to be affected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** A box to secure the key to the gate has been installed. This box is attached to the wall by the gate. This will allow for emergency access at all times. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	03/08/2011

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	3.1-19(b)		**program will be put into place** The Maintenance Supervisor will monitor for the presence of the key monthly when activating the fire panel. **-Compliance date: 03-08-11**	

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K0143	Based on observation and interview, the facility failed to ensure 2 of 2 oxygen storage and transfilling room's entry doors were provided with a self closing device on each entry door. LSC 8.2.3.2.3.1(2) requires a 45 minute rated door in a one hour enclosure which isn't a vertical opening. LSC 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing. This deficient practice could affect any resident, staff or visitor in the vicinity of the Moving Forward Hall oxygen storage and transfilling room and the Hall 2 oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 02/15/11, the Moving Forward Hall oxygen storage and transfilling room door and the Hall 2 oxygen storage and transfilling room door are each not provided with a self closing device on the door. Based on interview at the time of observation, the Maintenance Director acknowledged oxygen transfilling occurs in each room and acknowledged each room door is not equipped with a self closing device on the door.	K0143	**K143 Transferring of oxygen.** The facility does have an area separate from where residents are housed, that is mechanically vented, sprinkled and has ceramic or concrete floor. Signs are posted indicating transfer is occurring. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were identified. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** No residents were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** A self-closing device was placed on the door on 2 of 2 oxygen rooms. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**	03/08/2011

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	3.1-19(b)		**i.e., what quality assurance program will be put into place** The Maintenance Supervisor will monitor monthly for the proper function of the self-closing device. **Compliance date: 03-08-11**	